Office of Inspector General

Annual Report

State Fiscal Year 2008

Bart Bevers, Inspector General

OIG Mission Statement

We protect the integrity and ensure accountability in the health and human services programs, as well as the health and welfare of the recipients of those programs, by identifying, communicating and correcting activities of waste, fraud or abuse in Texas.

OIG Vision Statement

The Office of Inspector General (OIG) is the nationally recognized model for leveraging technology and collaborative partnerships to eliminate waste, abuse, and fraud. The value the OIG provides to ensure the health, safety, and welfare of all Texans is universally realized.

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1. Executive Summary

I am pleased to issue the Office of Inspector General's (OIG) report for State Fiscal Year (SFY) 2008, which ended August 31, 2008. This report provides a synopsis of SFY 2008 OIG recoveries and cost avoidance, an overview of our key accomplishments and projects, and presents a look at future OIG activities. During SFY 2008, OIG total recoveries were $122,032,765 through sanctions penalties, and recoupments. Total cost avoidance was $383,027,844.

In SFY 2008, OIG conducted a risk-based analysis to evaluate current and potential audit responsibilities. The result of this risk-based analysis was OIG's first ever comprehensive audit plan. In SFY 2008, OIG also developed a new business model in its Sanctions Section. By utilizing the new business model, OIG will continue to recover money from providers, assess administrative penalties, and exclude providers who have violated the law.

OIG continues to assess and enhance policies and procedures, and streamline the integrated fraud and abuse prevention and detection functions. We are devoted to enhancing our computer programs and technical infrastructure to enrich the quality of work papers, improve the ability to recoup overpayments, and increase efficiency.

The Office of Inspector General is the nationally recognized model for achieving its vision of leveraging technology and collaborative partnerships to eliminate fraud, waste, and abuse. We look forward to providing continued service to the State of Texas and its leadership, and assuring accountability and integrity to Texas taxpayers.

Bart Bevers
Inspector General

2. Background

The 78th Texas Legislature created the Office of Inspector General (OIG) in 2003 in order to strengthen the Health and Human Services Commission's (HHSC's) authority to combat fraud, waste, and abuse in health and human services (HHS) programs.

Authorized by section 531.102 of the *Texas Government Code*, OIG is responsible for the investigation of fraud, waste, and abuse in the provision of HHS. OIG fulfills its responsibility through the following activities:

- Issuing sanctions and performing corrective actions against program providers and recipients, as appropriate;
- Auditing the use of state or federal funds including contract and grant funds administered by a person or state agency receiving the funds from an HHS agency;
- Researching, detecting, and identifying events of fraud, waste, and abuse to ensure accountability and responsible use of resources;
- Conducting investigations, reviews, and monitoring cases internally, with appropriate referral to outside agencies for further action;
- Recommending policies that enhance the prevention and detection of fraud, waste, and abuse; and
- Providing education, technical assistance, and training to promote cost avoidance activities and sustain improved relationships with providers.

Overseen by a Governor-appointed Inspector General, OIG is a modern investigative arm with extensive expertise and diverse resources capable of rapidly and objectively responding to emerging HHS issues.

OIG has successfully strengthened its stakeholder relationships, including those with the State Auditor's Office, Texas Comptroller of Public Accounts, and Office of the Attorney General, enabling the state to achieve cost savings in a variety of HHS areas. To ensure quality, OIG operates in accordance with the National Association of Inspectors General Principles and Standards, and all audits are performed in accordance with United States General Accounting Office Government Auditing Standards.

Advancing the HHS mission and the Governor's Executive Order RP 36, dated July 12, 2004, OIG initiates proactive measures and deploys advanced information technology systems to reduce, pursue, and recover expenditures that are not medically necessary or justified. These measures and automated systems enhance the ability of OIG to identify inappropriate patterns of behavior and allow investigative resources to target cases with the strongest supporting evidence and greatest potential for monetary recovery.

OIG maintains clear objectives, priorities, and performance standards emphasizing:

- Coordinating aggressive investigative efforts to recover Medicaid overpayments;
- Allocating resources to cases that have the strongest supporting evidence and the greatest potential for monetary recovery; and
- Maximizing the opportunities for referral of cases to the Office of the Attorney General.

OIG routinely takes proactive measures to reduce errors in the billing, payment, and adjudication of claims for Medicaid services. These measures include fraud, waste, and abuse prevention training for Medicaid providers, health maintenance organizations, staff of the claims administrator, and provider organizations.

Other proactive measures undertaken by OIG include workgroups with major provider associations, increased use of professional medical consultants, and a number of projects designed to improve provider communication and education. OIG staff actively participates in the design of medical and program policy to reduce erroneous payments while maintaining or improving quality of care to the Medicaid beneficiary. These proactive efforts have allowed OIG and HHSC to increase cost-avoidance activities and sustain improved relationships with Medicaid providers.

3. Key Accomplishments and Recent Developments

3.1 Compliance Division

The Compliance Division reviews providers, vendors, and contractors to ensure compliance with all state and federal rules, regulations, and guidelines related to payment for reimbursable services; collects all identified overpayments for reimbursable services; educates providers, vendors, and contractors on submitting accurate information for reimbursable services; and refers providers, vendors, and contractors for suspected fraud, waste, and abuse when appropriate. The Compliance Division has two sections: Quality Review and Audit.

3.1.1. Quality Review Section

The Quality Review Section consists of three units:

- Limited Program;
- Utilization Review; and
- Women, Infants, and Children (WIC) Vendor Monitoring.

Limited Program Unit

To prevent the inappropriate use of medical services and to promote quality of care, the Medicaid program may restrict a Medicaid recipient to designated providers, through the Limited Program. The Limited Program assigns selected recipients to designated primary care providers and/or pharmacies. Recipients are assigned a designated provider when:

- The recipients receive duplicative, excessive, contraindicated, or conflicting health care services including drugs; or
- Review indicates abuse, misuse, or suspected fraudulent actions related to Medicaid benefits and services.

The Limited Program has increased efficiency by:

- Implementing changes to current processes and applications;
- Increased staffing; and
- Continuous monitoring of Limited program applications and interfaces to avoid interruption of recipient services.

Provider participation in the Limited Program is voluntary. The Limited Program continues to struggle with the lack of Primary Care Providers willing to participate. Based on Medicaid eligibility, the Limited Program averaged 378 recipients monthly in the program.

Utilization Review Unit

The Utilization Review (UR) Unit currently reviews nursing facility services rendered to Medicaid recipients using the 3652 Client Assessment Review and Evaluation (CARE) form to determine the appropriateness of the Texas Index for Level of Effort (TILE) submitted for payment. A total of 1,039 nursing facility reviews were conducted on-site with 33,420 CARE forms reviewed. In addition, 31 nursing facilities were placed on vendor hold. Under House Bill 867, the

74th Legislature mandated the unification of State and Federal methods for the assessment of and payment for nursing facility services. In 2006, the HHSC ordered that this transition to a single method should occur by September 1, 2008. Based on this mandate, Texas Medicaid will begin using the federal Minimum Data Set (MDS) assessment to validate the Resource Utilization Group (RUG) III 34 group assigned as payment for the services rendered for nursing facility residents. New training modules were developed for provider online training through Texas State University and implemented April 1, 2008. UR drafted rules to address program changes and requirements, evaluating necessary policy and procedures, and assessing statewide impact. Stakeholder input was obtained and considered. The rules are effective October 9, 2008.

In addition, the UR Unit piloted and is further implementing a secure scanning process for medical record documentation during nursing facility on-site reviews.

UR also conducts reviews of inpatient hospital claims for fee-for-service Medicaid recipients including medical necessity, Diagnosis Related Group (DRG) validation, and quality of care. The process involves a quarterly sample of inpatient hospital paid claims. Registered Nurses conduct both on-site and mail-in reviews. Final determinations are made by HHSC-contracted Physician consultants. Hospital reviews conducted, on-site and mail-ins, total 978 hospitals with 35,523 hospital claims reviewed for accuracy of payment.

WIC Vendor Monitoring Unit

During this reporting period, the WIC Vendor Monitoring Unit increased the number of invoice audits performed during the past year, resulting in increased recoveries for the WIC Program. In addition, WIC now identifies cost avoidance as part of their reporting measures. The WIC Vendor Monitoring Unit increased the number of invoice audits performed during the past year to 50, resulting in increased recoveries for the WIC Program. The Unit performed 349 Compliance buys and 199 in-store evaluations.

3.1.2. Audit Section

The Audit Section consists of five units:

- Subrecipient Financial Review Unit;
- Medicaid/CHIP Audit Unit;
- Outpatient Hospital/MCO Audit Unit;
- Contract Audit Unit; and
- Cost Report Review Unit.

The Audit Section continues to implement enhancements to existing processes and is incorporating new audit processes to achieve its mission.

Subrecipient Financial Review Unit

The Subrecipient Financial Review Unit (SFRU) is responsible for Single Audit Desk Reviews of reports submitted by subrecipients, quality control reviews of Certified Public Accountant (CPA) firms who conduct single audits of subrecipients, and limited–scope audits of subrecipients. The quality control reviews conducted on the CPA firms and the limited-scope audits are based on a risk assessment process, while desk reviews are conducted on all

single audit reports submitted by subrecipients of HHS agencies.

Desk Reviews - The SFRU completed a total of 768 desk reviews in SFY 2008. In addition to the routine desk reviews, the SFRU has continued to find ways to enhance accountability on fraud, waste, and abuse by maintaining consistency and/or continually modifying OIG's internal processes and procedures. Annually, the SFRU works with external auditors to ensure proper audit of HHSC compliance with the single audit requirements.

Quality Control Reviews - The SFRU completed a total of 122 Quality Control Reviews in SFY 2008.

Limited Scope Audits of Subrecipients – SFRU began developing an audit program and internal control questionnaire for limited scope audits in SFY 2008. SFRU also engaged the Business Analysis and Support Services (BASS) Unit to develop the internal control questionnaire in an electronic web-based format for subrecipients to complete on line. A risk assessment of subrecipients has been completed and audits identified for SFY 2009.

Medicaid/CHIP Audit Unit

The Medicaid/CHIP Audit Unit (MCAU) performs work to determine whether Medicaid and Children's Health Insurance Program (CHIP) contracts, including relevant information technology and data integrity aspects, have been carried out as written. All work is performed to further the OIG mission to investigate fraud, waste, and abuse in HHS services and enforce federal and state laws relating to those services.

MCAU completed two audits of the Medicaid claims administrator contracts. These audits resulted in questioned costs totaling $28.6 million. MCAU is in the process of concluding an audit of the Medicaid hospice care system mandated by section 531.084(a)(6) of the *Texas Government Code*. This audit is designed to ensure correct billing of pharmaceuticals in the Medicaid hospice care system, which provides services in long-term care facilities.

Additionally, the MCAU Information Technology (IT) audit unit concluded audits of the Medicaid claims processor and the Medicaid prescription claims processor. MCAU IT is currently performing a limited audit of the Disease Management Services contract.

Outpatient Hospital/MCO Unit

The Outpatient Hospital/MCO Unit (OHMCO) has finalized the development of a cost report audit methodology and completed fieldwork on 62 providers. The engagements encompassed individual audits of the cost reports submitted over a three-year period. The OHMCO Unit has finalized the associated reports on the completed audits which include 36 desk reviews and 26 field audits. In SFY 2008, the audits identified $100,010,079 for recovery. In addition, the Unit completed one managed care compliance plan review.

OHMCO will perform 60 desk reviews and 30 field audits on cost reports submitted by providers in SFY 2009. The Unit has also scheduled 12 managed care compliance plan reviews.

Contract Audit Unit

The Contract Audit Unit (CAU) is primarily responsible for auditing contract compliance to ensure program funds are properly used to provide contracted services, to ensure recipient funds are adequately managed, and to serve as a deterrent to fraud, waste, and abuse within programs. The CAU performs audits of pharmacies participating in the Vendor Drug Program, as well as audits of Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR).

CAU completed 15 Vendor Drug Program audits in SFY 2008 that resulted in $367,094 identified for recovery.

In SFY 2008, ICF/MR audits identified recipient refunds of $99,587, recoveries of $45,568, and underpayments of $161,409. The Unit completed 33 ICF/MR audits.

Cost Report Review Unit

The Cost Report Review Unit (CRRU) conducts field audits and desk reviews of provider cost reports and attendant compensation reports and provides other requested non-audit services. Field audits and desk reviews are designed to meet OIG's goal to identify and correct fraud, waste, and abuse in Medicaid and non-Medicaid programs and are performed in accordance with applicable sections of the *Texas Administrative Code*, Title 1, Chapter 355.

The results of field audits and desk reviews are used by HHSC's Rate Analysis Division (RAD) in its rate setting responsibilities. RAD uses the adjusted statistical and financial information to recommend future reimbursement rates for program services to the Texas Legislature. For SFY 2008, CRRU completed a total of 4,169 field audits, desk reviews, and modified reviews, and identified $86,497,157 in net disallowed costs.

CRRU has made changes designed to enhance the efficiency and effectiveness of its audit processes. CRRU has completed development of the risk assessment methodology used in selecting samples of cost report projects to be conducted for each type of review. CRRU is currently completing pilot project audits for the House Bill 2540 Work Group. This workgroup was tasked to simplify, streamline and reduce costs associated with Medicaid cost reporting and auditing.

Medicaid Fraud Detection and Abuse Prevention Training

Texas State University Training

OIG continues its contract with Texas State University at San Marcos (TX State) for the purpose of providing Medicaid fraud, waste, and abuse training. Under the provisions of Section 531.105 of the *Texas Government Code*, HHSC provides Medicaid fraud, waste, and abuse training to Medicaid contractors, providers, their

employees, and to state agencies involved in the administration of HHS programs on the identification and referral of fraud, waste, and abuse in the Medicaid program.

Effective September 1, 2008, nursing facilities changed from the Texas Index for Level of Effort (TILE) reimbursement methodology to the Resource Utilization Group (RUG) III system. Throughout SFY 2008, OIG worked with TX State to develop a distance-learning program for this new material. The program was launched in April 2008. All facilities were required to complete the initial training to submit Minimum Data Set forms for reimbursement, which became effective September 1, 2008. The existing TILE distance-learning program will run concurrently through September 1, 2009 when TILE is completely phased out.

Fraud, waste, and abuse are significant components of both the TILE and RUG distance-learning programs. These courses are intended for Long Term Care (LTC) nurses and other providers of long-term care in an institutionalized setting, and for nurses and providers associated with the Community Programs administered by the Department of Aging and Disability Services (DADS). The distance-learning program provides the most efficient and economical training on Medicaid fraud, waste, and abuse detection and prevention. Course information and registration is available at: https://oig.hhsc.state.tx.us/Reports/Training.aspx

3.2 Chief Counsel Division

The Chief Counsel Division provides general legal services to OIG, renders advice and opinions on HHSC programs and operations, and provides all legal support of OIG's internal operations. This office imposes administrative actions and penalties against healthcare providers and litigates those actions. The Chief Counsel Division includes two sections: Legal and Sanctions.

3.2.1. Legal Section

The Chief Counsel Division issued "Provider Self-Reporting Guidance" (Guidance) during SFY 2007 to encourage health care providers to investigate and report voluntarily matters involving possible fraud, waste, and abuse or inappropriate payment of funds under state administered programs. The Chief Counsel Division received nine new self-reports during SFY 2008.

The Legal Section helped prepare a statewide predicate manual for distribution to statewide District Attorneys' offices. The manual instructs prosecutors on charging and trying criminal cases of Food Stamps, Temporary Assistance for Needy Families (TANF), and Medicaid fraud by recipients under the Texas Integrated Eligibility Redesign System (TIERS) system.

The Legal Section assisted the Medicaid CHIP Division in completing a rewrite of provider enrollment policy and procedures for the Texas Medicaid Provider Procedures Manual that clarifies and completes policy on provider enrollment and re-enrollment requirements, thereby enhancing the ability to take administrative enforcement action when a provider fails to comply. The Section also completed a rewrite of mandatory exclusion policies and procedures.

3.2.2. Sanctions Section

The Sanctions Section was restructured in SFY 2008 to ensure that attorneys conduct a legal review on all completed provider investigations and that the most appropriate sanctions and administrative actions are imposed. Upon completion of the legal review, the Sanctions Section sends notice of potential administrative action to the provider, conducts education and informal reviews of each case, and litigates administrative appeals when requested. The Sanctions Section also manages non-monetary sanctions against providers, including review of provider enrollment decisions, payment holds, pre-payment reviews, and exclusions from the Medicaid program.

OIG recovers all overpayments made to providers within the Medicaid or other HHS programs pursuant to 1 TEX. ADMIN. CODE § 371.1703(a). The Sanctions Unit collects and disburses all overpayments and civil monetary penalties recovered in global settlement awards, which arise out of litigation filed on behalf of HHSC by the Office of Attorney General's Civil Medicaid Fraud Division. OIG reports all global settlement overpayments and civil

monetary penalties collected and disbursed as a distinct performance measure. The Office of Attorney General's Civil Medicaid Fraud Division may report the same overpayments and penalties in its annual or semi-annual reports. Although both offices have valid reasons for reporting the global settlement recoupments, the recoveries are the same, and the reported amounts should not be summed or duplicated for budgeting or decision-making purposes.

3.3 Enforcement Division

The Enforcement Division conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or by HHS beneficiaries and of unjust enrichment by providers. These investigative efforts lead to criminal convictions, administrative sanctions, or civil monetary penalties. The Enforcement Division has three sections: General Investigations, Medicaid Provider Integrity, and Internal Affairs.

3.3.1. General Investigations Section

General Investigations (GI) staff conducts recipient eligibility fraud investigations in Food Stamps, TANF, Medicaid, Children's Health Insurance Program (CHIP), and other HHS programs. GI also coordinates and conducts covert operations involving retailers who illegally exchange food stamps for money. GI units consist of claims investigators and/or field investigators who establish fraud and non-fraud overpayments claims for recovery that return funds to the state treasury and agency programs. Fraud investigations are filed with local prosecutors or handled through an Administrative Disqualification Hearing (ADH). In SFY 2008, GI processed 39,707 referrals. GI referred 3,812 fraud cases for prosecution and completed 6,059 fraud cases administratively. Additionally, GI investigated 196,149 data matches. The table on the following page provides a summary of General Investigations activity for SFY 2008.

GI successfully implemented the Investigations Module of the Automated System for OIG (ASOIG) at the beginning of SFY 2008. This module incorporated a number of separate systems used by GI staff. ASOIG enables GI staff to initiate referrals effectively, distribute workloads, investigate referrals, dispose of referrals and investigations, generate correspondence, and interface with other systems to receive and transmit information. Work is ongoing for the ASOIG reports capability.

Women, Infants, and Children Program Unit

On September 1, 2008, the Women, Infants, and Children Program (WIC) investigations function was transferred to GI. This transfer was warranted due to the nature of WIC Investigations dealing with recipient fraud.

Annual Certification of TIERS Investigations

OIG used the TIERS Historical Case Report (THCR) System to retrieve the TIERS data necessary to investigate, refer and prosecute fraud cases in SFY 2008. OIG continually works with Enterprise Applications staff to resolve issues as they are identified with the THCR System.

GENERAL INVESTIGATIONS SUMMARY SFY 2008					
Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Claims Established	$3,766,436	$5,954,273	$6,145,677	$5,174,202	**$21,040,587**
Collections	$3,142,922	$6,628,511	$8,352,657	$5,191,267	**$23,315,356**
Disqualification Cost Avoidance	$0	$0	$1,361,470	$7,635,212	**$8,996,682**
Cost Avoidance Income Eligibility Verification System (IEVS) Data Matches	$224,695	$244,818	$261,162	$564,461	**$1,295,136**
Cost Avoidance Recipient Data Matches	$117,021	$138,378	$156,705	$228,018	**$640,122**
Referrals Received	10,802	12,052	13,059	23,871	**59,784**
Referrals Closed	9,771	10,143	10,277	9,516	**39,707**
Percent of Cases Completed w/in 180 Days (Year-To-Date)	84.16%	85.52%	87.37%	87.63%	**87.63%**
Cases Referred for Prosecution	776	945	1,034	1,057	**3,812**
Admin. Disqualification Hearings (ADH) Cases Completed	1,033	1,566	1,762	1,698	**6,059**
Cases Adjudicated	259	252	361	710	**1,582**
Civil Disqualifications	0	0	815	4,788	**5,603**
Income Eligibility and Verification System (IEVS) Matches Cleared	34,036	37,148	37,982	69,659	**178,825**
Recipient Data Matches Cleared	3,167	3,745	4,241	6,171	**17,324**

3.3.2. Medicaid Provider Integrity Section

The Medicaid Provider Integrity (MPI) staff is primarily devoted to evaluating complaints and conducting investigations of provider fraud, waste, and abuse in the Texas Medicaid Program. Investigations may involve statistical sampling and may focus on specific geographic areas that show a historical propensity toward fraud, waste, and abuse. Cases of suspected fraud are referred for criminal investigation to the Office of Attorney General's Medicaid Fraud Control Unit (MFCU). In SFY 2008, MPI made 270 referrals to the MFCU. MPI investigations can also result in referrals to outside entities that may have parallel jurisdiction or regulatory authority. In SFY 2008, MPI made 176 referrals to outside entities.

In addition to provider investigations, MPI staff also presents recommendations related to all Medicaid policies affecting providers, documentation requirements, and any program areas that affect providers and the ability to identify potential overpayments. MPI conducts on-site inspections of Durable Medical Equipment (DME) companies enrolling in the Medicaid Program. This inspection process helps achieve program integrity functions by ensuring provider applicants are in compliance with applicable laws and regulations to become a DME provider in the Medicaid program. For SFY 2008, MPI completed 307 on-site inspections, an increase of 24% from the previous fiscal year.

This table summarizes Medicaid Provider Integrity activity during SFY 2008.

MEDICAID PROVIDER INTEGRITY
SFY 2008

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Cases Opened	142	110	96	107	**455**
Cases Closed	93	88	29	221	**431**
Cases Referred to Attorney General	24	67	67	112	**270**
Cases Referred to Other Entities	96	25	17	38	**176**
On-Site Provider Verifications Completed	62	80	79	86	**307**
Cases Referred to Sanctions	5	7	6	3	**21**

OIG and OAG Interagency Coordination

The OIG and the Office of the Attorney General (OAG) have established guidelines under which provider payment holds and exclusions from the Medicaid program are implemented. Timelines and minimum standards have been established by the OIG for making referrals between the MFCU and

the OIG. This has enhanced the timely investigation of potentially fraudulent providers.

The Governor's Executive Order RP-36, dated July 12, 2004, directed all state agencies to establish wide-ranging efforts to detect and eliminate fraud in government programs.

OIG continues to strengthen and enhance coordinated efforts to execute the Governor's directive, and both OIG and the OAG recognize the importance of partnership and regular communication in this effort to fight fraud, waste, and abuse in the Medicaid program. Thanks to a renewed cooperative spirit and focused efforts, both agencies continue to achieve the following:

- An increased commitment to promptly send and/or act upon referrals, accomplished by improving turnaround time in addressing referrals;
- Regular case presentation meetings to introduce critical cases to MFCU staff, to conduct parallel investigations;
- Communication on cases through entire staff levels, ensuring all case resources are shared, and efforts are not duplicated; and
- Monthly and quarterly meetings are held between the appropriate OIG and OAG staff to discuss case information, Medicaid policies and issues, agency coordination and other related matters; maintaining a close working relationship with MFCU on numerous investigations of DME providers during SFY 2008 in the Harris county area. MPI shared all investigative information with the MFCU. This collaborative effort has led to multiple arrests and indictments of providers who have been committing fraud against the Texas Medicaid Program.

Managed Care Special Investigative Units

In accordance with Section 531.113 of the *Texas Government Code*, all Managed Care Organizations (MCOs) contracting with the State of Texas must adopt a plan to prevent and reduce fraud, waste, and abuse and file their plan annually with OIG for approval. For SFY 2008, OIG received 39 complaint referrals from MCOs based on their mandated Special Investigative Units (SIUs).

MPI helps coordinate efforts to assist MCOs in their mission of identifying, preventing, and reducing provider and recipient fraud, waste, and abuse within MCOs or their subcontractors as it relates to Medicaid Managed Care and CHIP. OIG's Enforcement Division expects to develop productive relationships with MCOs through mutual contributions of expertise and dedication in achieving this goal.

3.3.3. Internal Affairs Section

Effective September 1, 2007, the State Investigations Unit (SIU) was changed to the Internal Affairs Section (IAS). The IAS will retain its current duties and responsibilities to identify and reduce fraud, waste, and abuse, and misconduct involving contractors, vendors, service providers, and employees through

independent, fact-based investigations, reviews, and analyses in accordance with applicable federal and state laws.

The IAS includes: the Forensic Research and Analysis Team (FRAT), the Program Investigations Team (PI), the Special Investigations Response Team (SIRT), the Vital Statistics Investigations Team, and the Central Investigations Team (CIT). The CIT was created within IAS to conduct investigations involving fraud, waste, and abuse or misconduct within HHS programs, along with PI and SIRT.

IAS in conjunction with Business Analysis and Support Services (BASS) is in the final testing phase of the web-based, centralized, security-driven case management system. The system has been developed and is being tested for accuracy, user friendliness, workflow, and procedures describing how information will be entered and captured for reporting. The new case management system will replace the current stand-alone Microsoft Access computer database inherited from the legacy agency operations.

The new system will automate and standardize most of the investigative logging, tracking, reporting, and writing tasks. The case management system will use the "wizard" approach to build a case record, guiding the user through case screens to create a case. This system has the added benefit of ensuring that critical data is not left out of the information collection process.

Upon full deployment of Encase Enterprise, FRAT will have the latest technology to enable an immediate response to incidents of computer misuse, thorough analysis of electronic media, and efficiency in obtaining evidence. Utilizing this system will create substantial cost savings in staff time, computer down-time, and damaged hard drives.

This table summarizes the production activities of Internal Affairs for SFY 2008.

INTERNAL AFFAIRS SUMMARY
SFY 2008

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Complaints Received	183	155	120	174	**632**
Investigations Completed	127	114	95	129	**465**
Cases Referred To Law Enforcement	38	13	11	41	**103**
Administrative Referrals	74	101	81	86	**342**

3.4 Operations Division

The Operations Division brings together the diverse functions that contribute to the overall organizational effectiveness of OIG. The Operations Division consists of two sections: Technology Analysis, Development, and Support, and Business Operations and Support Services.

The two sections of Operations create consistency of purpose, uniform actions, and a stewardship of resources. This Division is instrumental in keeping the flow of information open across divisions, developing and implementing program policies, and improving organizational capabilities.

3.4.1. Technology Analysis, Development, and Support Section

The Technology Analysis, Development, and Support (TADS) Section is comprised of the three units: Third Party Resources (TPR), Business Analysis, and Support Services (BASS), and Research, Analysis, and Detection (RAD).

The Technology Analysis, Development, and Support (TADS) Section directs and monitors the development, implementation, and coordination of policies and procedures encompassing OIG information technology systems. TADS is also responsible for working the results of the Texas Medicaid Fraud and Abuse Detection System (MFADS) generated targeted queries and models. This Section provides oversight and direction on cases identified by the Medicaid claims administrator, Affiliated Computer Services (ACS) and Texas Medicaid and Healthcare Partnership (TMHP), through the federally required Surveillance and Utilization Review Subsystem (SURS).

During SFY 2008, OIG exercised the final option to extend the MFADS contract. The contract will terminate on August 31, 2009. In the upcoming year, TADS and other OIG staff will be involved in the competitive bid process for the new MFADS contract.

TADS staff has continued with the following technological developments:

- *Create a secure environment for OIG data and applications* – OIG has enhanced network security and controls by:
  - Installing additional servers for software development, testing, and system administration for secure and non-secure data; and
  - Establishing Disaster Recovery/Offsite storage space at the John H. Winters Building located at 701 W. 51st Street, Austin, Texas.
- *Installation of third party applications that include*:
  - Feedback Server application – gives OIG the ability to create dynamic and professional looking surveys for internal and external use;
  - Evidence Tracker – application for tracking evidence for OIG in Texas;
  - Code Manager 2008 and quarterly updates – used by OIG for Current Procedural Terminology (CPT®)

code registered with the American Medical Association (AMA); and
    - ACL – used by OIG Compliance/Audit.
- *Development and deployment of an OIG Public Homepage* – Additional development work has taken place to allow a secure liaison between OIG and the public. The website will be compliant with *Texas Administrative Code*, Title 1, Chapter 206 and Section 508 of the Rehabilitation Act (36 CFR § 1194 (2006)).
- *Continued Upgrades to the OIG internal portal homepage* – The official internal homepage for the OIG.
- *Continued development and internal testing of Phases I, II, and III of the Internal Affairs case management system* – It is a web-based, centralized, security–driven case management system to streamline the current OIG Internal Affairs paper-based operation.
- *Improvements to the external Waste, Abuse, and Fraud Electronic Reporting System (WAFERS) website* – This application allows any state employee or private citizen to report fraud, waste, and abuse to OIG.
- *Continued development of the new internal complaint tracking system* – This system will be used for all external referrals that are received (via Hotline, e-mail, letter, fax, etc.) and for internal referrals from one OIG area to another.
- *Additional improvements to the internal project request application that is accessed via the OIG portal* – This application will be used by designated OIG staff to request TADS assistance.
- *OIG Minimum Data Set* – Federal system based on the Minimum Data Set Resident Utilization Group (MDS RUG). BASS staff was involved with several workgroups and the creation of the project charter.
- *Development and deployment of a BASS Timekeeping system* – This system is used by BASS to track time for work that will be associated with the various OIG areas. This information will be sent to HHSC Financial services so the proper funding source can be determined.
- *Development and deployment of an OIG Portal File sharing application* – This allows OIG staff to share files even when they belong to different domains.
- *Improvements to the Single Audit Sub-recipient Website* – Additional design requests for the Single Audit determination web form have been implemented for the OIG Single Audit Unit.

Third Party Resources Unit

Third-party payments and reimbursements for SFY 2008 exceeded $148 million. To further increase recovery efforts, HHSC continues to search for new methods of identifying and pursuing liable third parties. As a result, HHSC is working on a contract amendment that will enhance and/or expand the following TPR activities:

- *Pharmacy Accounts Receivables (AR) claim level posting* – Historical posting practices relied on the posting of payments at a recipient level and did not include the posting of denied claims. Under this amendment, a more automated and comprehensive

approach to AR posting and follow-up will be utilized.

- *Medicare Identification and Recovery Initiatives* – Supplemental Medicare data matching and recovery initiatives will be performed to ensure full utilization of Medicare as a source for other available insurance to Medicaid recipients.
- *Medicare Part D Gap Recoveries* – Efforts will be in place to recover pharmacy claims paid by Medicaid when not paid by Medicare Part D as designed.
- *Third Party Liability (TPL) Verifications*– OAG-excluded populations will be included under a new verification and recovery process.
- *Overpayment Recovery Services (ORS)* – Additional contacts will be made to insurance companies that provide benefits to Medicaid eligible recipients.
- *Provider Audit Recoveries* – A subcontract will be entered into to recover credit balances from providers, who, due to their size, have not been selected by the current credit balance recovery subcontractor.
- *Medicare Part D* – A workgroup for Medicare Part D was formed to discuss recent findings that Part A & B dates are not consistently formatted in System for Application, Verification, Eligibility, Reports, and Referrals (SAVERR) and TIERS. This inconsistency impacts Medicaid payments on claims when another payer already exists. The discussions focused on current Medicare A & B dates in the eligibility systems, concerns about current source file (Bendex), costs associated with missing A/B dates, and the feasibility of using the Medicare Enrollment Database instead of, or in addition to the current Bendex process.

The workgroup is finalizing an analysis of the current Bendex processing and has recently obtained a copy of a possible alternate source of Medicare data, CMS' Medicare Enrollment Database. Once conclusions are developed about the quality of current processes and the new data source, the workgroup will send a memo to the Executive Commissioner with recommendations about how to improve the quality of Medicare Part A and Part B data in the current Medicaid eligibility systems.

This table shows TADS activities for SFY 2008.

TADS SUMMARY (NOT INCLUDING TPR) SFY 2008					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Cases Opened	705	875	1,663	864	**4,107**
Cases Closed	550	403	1,114	1,086	**3,153**
Cases Referred to Attorney General	0	0	0	0	**0**
Dollars Recovered	$428,773	$611,154	$1,188,662	$1,949,044	**$4,177,634**
Cost Avoidance Due to Provider Prepayment Review Process (all OIG)	$13,642	$10,247	$137,860	$57,274	**$219,024**

3.4.2. Business Operations and Support Services Section

The Business Operations and Support Services Section (BOSS) is comprised of four units; Program Integrity Research (PIR), Quality Management Services (QMS), Communications and Governmental Affairs (CGA), and Staff Development and Training Team (SDT).

Program Integrity Research Unit

PIR continues to conduct criminal history background checks for all potential Medicaid, Medicaid Managed Care, and Children with Special Health Care Needs (CSHCN) Services program providers submitting an enrollment application through TMHP. Additionally, criminal background checks are performed for any person or business entity that meets the definition of indirect ownership interest, as defined in Section 371.1601 of the *Texas Administrative Code*, applying to become a Medicaid provider, or applying to obtain a new provider number, or a performing provider number. Details of these changes were made available in the January/February 2006 *Texas Medicaid Bulletin*, No. 192 and the February 2006 *CSHCN Provider Bulletin*, No. 57. In December 2006, MPI began conducting criminal history background checks on *all* Medicaid providers currently enrolled through TMHP, the state's claims administrator. PIR consists of one Team Lead and four Research Specialists. During SFY 2008, PIR conducted 30,876 criminal history checks on Medicaid provider applicants and current Medicaid providers, a 54% increase from the SFY 2007 total of 20,100.

Quality Management Services Unit

The Quality Management Services Unit (QMS) upholds OIG conformance to professional standards established by the Association of Inspectors General. This Section exists to: 1) provide reasonable assurance that OIG processes and work

performed adhere to standards and established OIG policies, procedures, and performance criteria; and 2) enhance operational economy, efficiency, and effectiveness. To facilitate pursuit of these objectives, the unit incorporates various business process risk management and policy review and development functions. A summary of significant contributions of QMS includes:

- Assessing the sufficiency, competence, relevance, validity, reliability, and presentation of case evidence;
- Developing and deploying policies, procedures, tools, and technical assistance to intra-agency and inter-agency project groups in standards compliance, issue scoping and materiality, quantitative and qualitative data acquisition and analysis, findings, development, and reporting;
- Developing and delivering automated risk assessment tools for use in quantitatively evaluating issue, policy, and project risk across the entire HHSC Enterprise;
- Continuing work on the long-term integration of OIG organizational structure, strategic plan, budget, and performance measures;
- Developing and maintaining a single-source, fully automated means for the collection, analysis, norming, trending, reporting, integration and accountability of OIG division, section, and unit performance measures information;
- Standardizing the gathering, reporting, quality control, testing, integrity, and retention of internally and externally reported performance information and auditing such information from OIG's inception to the present;
- Providing substantial input into the development and assisting the deployment of a quality control review process for the transition of cases from OIG MPI to OIG Sanctions;
- Designing sampling methodologies for use in UR reviews of long-term care facilities to facilitate the transition from TILEs to RUGs;
- Designing and deploying quantitative/qualitative risk assessment for use in calculating statistically valid risk indicators for the Cost Report Audit Project, to cover over 3,000 vendors, 47 quantitative variables, and 15 qualitative variables;
- Developing, deploying, and coordinating risk assessments for both business process improvement, and auditing applications;
- Designing, delivering, administering, and reporting results of OIG-wide organization culture assessments;
- Providing input on and coordinating OIG responses to internal and external requests for information, projects, and initiatives (e.g., state and federal policy impact studies, performance measures reporting, administrative rules, conflict of interest statements, legislative requests, interim committee reports, Sunset Commission reviews, policies, special reports, and various contract provisions and amendments);
- Advising and providing technical support to HHSC Internal Audit and Texas MCO-SIUs in sampling, data analysis, and reporting;

- Advising and providing technical support to HHSC agencies in their evaluation of vendor responses to Requests for Proposals;
- Training city and county auditors and investigators in gathering, sampling, testing, extrapolating, and reporting quantitative and qualitative case information;
- Serving as State Liaison and/or (Sub)Committee Member with the Centers for Medicaid and Medicare Services (CMS), the Federal Medicaid Integrity Project (MIP), the National Association for Medicaid Program Integrity, the CMS Committee on Performance Metrics, the CMS Technical Advisory Groups on both PERM and fraud, waste, and abuse; and
- Designing and delivering training curricula and courses at the United States Department of Justice National Medicaid Integrity Institute.

QMS staff continues to study, and, where appropriate, standardize OIG's functions and operations, provide information to management and staff, and pursue production of office-wide quality assurance protocols.

Federally Mandated Medicaid Integrity Program

The MIP provides federal oversight of each State's Medicaid program integrity efforts. The MIP is CMS' first national strategy for detection and prevention of Medicaid fraud, waste, and abuse. The MIP is bolstered by $148 million in annual funding for FFY 2009 and 100 new employees. This oversight includes an annual State Program Integrity Assessment (SPIA), which will develop and deploy program integrity performance measures, share best practices, and recommend program integrity improvements. The State of Texas was one of the first states to undergo a program integrity review with the purpose of evaluating the states' fraud, waste, and abuse procedures. This review occurred in April 2008, and although the State is waiting for the final report from CMS, an exit conference indicated that with few exceptions, Texas was in compliance with federal regulations and was commended on its efforts to eliminate fraud, waste, and abuse in Medicaid.

Moreover, the MIP includes a Medicaid Integrity Audit Program (MIAP) under which federal contractors audit Medicaid provider claims. These audits involve: (1) reviewing the actions of individuals or entities furnishing items or services in return for Medicaid payment to determine whether fraud occurred; (2) auditing claims for items or services rendered or administrative services, including cost reports, consulting contracts, and risk contracts; (3) identifying overpayments; and (4) educating providers, managed care organizations, and beneficiaries on payment integrity and quality.

Once federal auditors identify overpayments, the state has 60 days to collect the overpayment and return the federal share to Washington. If a state cannot collect some or all of the overpayment, the federal 60-day rule still

requires the state to reimburse the entire federal share of the overpayment. Thus, the state is at risk of losing 100% of the identified overpayments.

QMS staff is expending substantial time and effort related to MIP through:

- Serving on the MIP Advisory Committee;
- Serving as the Chair of the Performance Measures Workgroup of the MIP Advisory Committee;
- Serving on the Fraud and Abuse (F&A) Technical Advisory Group (F&A TAG);
- Collaborating with Federal MIP staff and Federal contractors responsible for MIP Program administration to develop policies, processes, criteria, and performance measures; and
- Working with Federal contractors to implement provider selections and audit processes.

Communications and Governmental Affairs Unit

The Communications and Governmental Affairs Unit provides current and relevant information to public officeholders, other state entities, stakeholders, and the public. Other tasks encompass informing appropriate officials through oral or written reports of the results of important OIG projects and any appropriate issues encountered that may merit an official's attention. The Unit is also involved in coordinating the production and distribution of a variety of reports to state and federal agencies.

A crucial component of the unit is developing and implementing external relations communication strategies and methods to communicate effectively with legislative bodies, interested parties, and the public regarding the mission of OIG.

The unit continues to refine its use of the Secured Issues Management System (SIMS) software for the 81st Legislative Session. This software, developed in-house, provides the capability to document, track, and report on daily activities with a major focus on legislative issues, such as assignments for bill tracking and legislative and constituent inquiries.

Legislative contacts focus on responding to legislative requests for assistance with issues affecting OIG. Responses to legislative and constituent inquiries are coordinated through the appropriate subject matter experts within OIG and then relayed to the requesting offices or individuals to ensure that all questions are resolved in a timely manner and any further issues are addressed.

Policy improvement is vital in preventing and controlling fraud, waste, and abuse in HHS. OIG continually develops and communicates its own internal policies and procedures and both assesses and recommends policies, which directs OIG to "recommend policies promoting economical and efficient administration of funds … and the prevention and detection of fraud, waste, and abuse in administration of those funds (Section 531.102(h)(6) of the *Texas Government Code).*"

The HHSC Medicaid/CHIP Division (MCD) leads the Benefits Management Workgroup (BMW) in defining medical policy for Medicaid Fee-For-Service and Managed Care programs. OIG Operations plays a key role in the BMW process, working collaboratively with MCD and other divisions in the planning, implementation, and monitoring of medical policy changes that may result in cost avoidance or cost savings by reducing fraud, waste, and abuse. OIG Operations works office-wide to ensure, when possible, that staff concerns are identified through investigations and data analysis are addressed in medical policy.

The BMW and OIG are working to ensure that reimbursement is disallowed when services are used in a manner that is inconsistent with nationally accepted coding standards. Policy development includes review and alignment with the American Medical Association CPT®. The policy development process also includes review of the CMS National Correct Coding Initiative (NCCI) edits, which outlines CPT procedure code combinations where one code denies and the other pays. Policy development also addresses standards for medical record documentation.

Staff Development and Training Unit

Provider education is an integral element of any fraud prevention plan. In November 2005, HHSC MCD executed new joint procurement contract with Medicaid/CHIP MCOs. These contracts obligate MCOs to designate executive and essential personnel to attend mandatory training in fraud, waste, and abuse detection, prevention, and reporting no later than 90 days after MCO startup or contract execution as applicable.

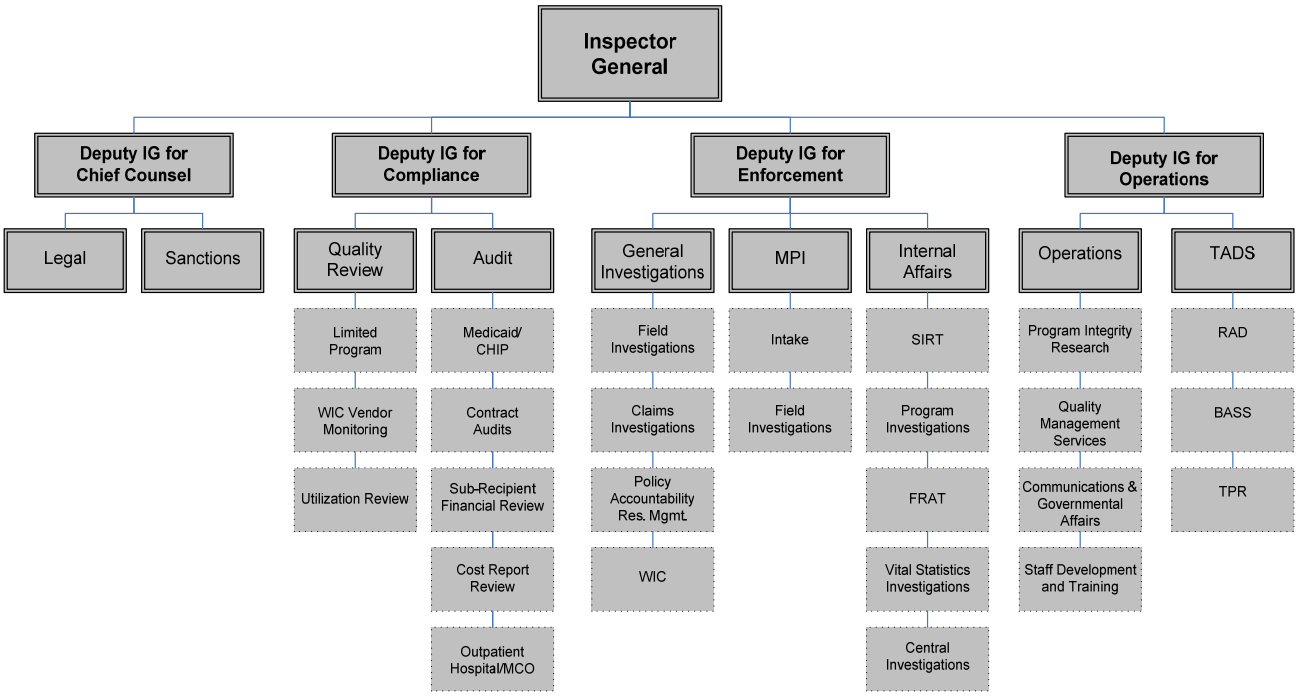
OIG conducted fraud, waste, and abuse training to address the mission of OIG and the scope of its investigations, specific beneficiary, provider, and MCO fraud issues, and developing organizational fraud controls.

The Staff Development Training Unit, in accordance with Section 531.105 of the *Texas Government Code*, provides training to Medicaid providers, contractors, their employees, and staff from other state agencies that administer HHS programs, on the identification and referral of fraud, waste, and abuse in the Medicaid program. These seminars discuss examples of actual schemes used to defraud the Medicaid program, ways to detect them, and measures to prevent them. Participants are encouraged to ask questions and interact with the trainers. Program content is adapted to meet the needs of specific groups or organizations.

The objectives of the training are to educate and inform about:

- What constitutes Medicaid fraud, waste, and abuse;
- The obligation to report Medicaid fraud, waste, and abuse;
- How to identify potential Medicaid fraud, waste, and abuse; and
- How to report potential Medicaid fraud, waste, and abuse.

Appendix A. OIG Organizational Chart



Appendix B. OIG Recovery and Cost Avoidance Statistics

SANCTIONS, PENALTIES, AND RECOUPMENTS SFY 2008					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Sanctions	$590,063	$6,147,179	$733,032	$26,132,379	**$33,602,653**
Civil Monetary Penalties (CMP)	$51,493	$85,919	$99,709	$27,604,280	**$27,841,402**
Utilization Review (Hospitals)	$5,227,888	$8,125,642	$6,556,665	$2,779,306	**$22,689,502**
Utilization Review (Nursing Homes)	$1,784,131	$2,636,348	$3,174,863	$2,732,638	**$10,327,981**
Technology Analysis, Development & Support (TADS)	$428,773	$611,154	$1,188,662	$1,949,044	**$4,177,634**
General Investigations Collections (Food Stamps, TANF, and Medicaid Recipients)	$3,142,922	$6,628,511	$8,352,657	$5,191,267	**$23,315,356**
WIC Investigation Recoveries	$258	$698	$8,567	$13,694	**$23,217**
WIC Vendor Monitoring	$3,997	$0	$17,591	$33,433	**$55,020**
Total	**$11,229,527**	**$24,235,450**	**$20,131,747**	**$66,436,041**	**$122,032,765**

THIRD-PARTY PAYMENTS AND REIMBURSEMENTS SFY 2008					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Provider/Recipient Refunds	$849,297	$762,581	$786,113	$783,177	**$3,181,168**
Texas Automated Recovery System	$4,333,318	$6,076,114	$5,896,707	$8,385,714	**$24,691,854**
Pharmacy	$6,763,653	$9,366,740	$6,972,631	$21,698,709	**$44,801,733**
PPRA	$128,565	$527,646	$1,485,157	$1,387,074	**$3,528,442**
Provider Audit Recoveries	$6,368,338	$4,738,926	$4,853,489	$5,107,299	**$21,068,052**
Tort	$4,933,560	$3,499,375	$6,586,998	$5,157,763	**$20,177,696**
Cash Medical Support	$4,513,245	$6,146,428	$10,468,253	$9,866,534	**$30,994,461**
Total	**$27,889,976**	**$31,117,811**	**$37,049,349**	**$52,386,271**	**$148,443,407**

COST AVOIDANCE SFY 2008					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Sanctions *	$651,395	$4,814,499	$2,748,507	$2,486,942	**$10,701,344**
TADS Provider Prepayment Review Process	$13,642	$10,247	$137,860	$57,274	**$219,024**
Third Party Resources	$65,473,435	$85,864,478	$106,796,886	$102,305,239	**$360,440,039**
Disqualifications (Food Stamps & TANF Recipients)	$0	$0	$1,361,470	$7,635,212	**$8,996,682**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF, and Medicaid Recipients)	$224,695	$244,818	$261,162	$564,461	**$1,295,136**
Recipient Data Matches (Food Stamps, TANF, and Medicaid Recipients)	$117,021	$138,378	$156,705	$228,018	**$640,122**
WIC Vendor Monitoring	$191,333	$216	$535,090	$8,858	**$735,498**
Total	**$66,671,521**	**$91,072,638**	**$111,997,681**	**$113,286,005**	**$383,027,844**

*Under the former methodology, Sanctions cost avoidance would have totaled $48,634,149. See the "Sanctions" section on page 31.

B.1 Cost Recovery

Total recoveries[1] for State Fiscal Year (SFY) 2008 were $270,476,172 (all funds).

Recovery dollars are defined as actual collections, recoupments, or hard dollars collected by OIG. Recoveries, as reported by OIG, do not include any projects, dollars identified, or any other type of "soft-money" or future settlement payments. TPR activities are handled through the Texas Claims Administrator contract and the Texas Medicaid Management Information System (MMIS). The TPR Unit has oversight and contract management responsibilities for TPR activities and functions handled by the Claims Administrator. Therefore, as the state TPR policy and oversight lead, OIG reports the cost recovery numbers generated by the Claims Administrator.

Based upon previous cost recovery methodologies, recoupments for SFY 2007 were $418,079,369, compared to $490,577,227 for SFY 2008. Based upon more accurate current cost recovery methodology, total recoveries for SFY 2007 were $162,443,827, compared to $270,476,132 for SFY 2008.

OIG Recoveries	Prior Methodology	Revised Methodology
SFY 2007	$418,079,369	$162,443,827
SFY 2008	$490,577,227	$270,476,172

Differentiating Factor Is Inclusion/Exclusion of Provider Receipt of Other Insurance	
SFY 2007	$255,635,542
SFY 2008	$220,101,055

B.2 Cost Avoidance

Cost avoidance is a reduction to a state expenditure that would have occurred, or was anticipated to occur, without OIG intervention.

Cost avoidance dollars are calculated differently by business function. OIG takes a conservative approach in reporting these dollars. Following is a summary of the methodologies by business function, which is used for calculating cost avoidance.

Sanctions

Sanctions cost avoidance dollars are estimated savings to the state Medicaid program, which result from an administrative action and/or imposing a sanction against a Medicaid provider.

These savings are computed as follows:

[1]OIG has excluded from this report the Third Party Resources (TPR) category called "provider receipt of other insurance" (at times referred to as "other insurance credits" in prior reports). This category does not reflect a true cost recovery or cost avoidance savings to the state but instead documents other insurance payments made directly to providers from other insurance entities. While these payments may reduce Medicaid outlays, since the Texas Claims Administrator does not actually collect them, their removal more accurately reports the actual cost recovery amount collected due to recovery activities.

Recoupment of Overpayments Identified for a Provider with Exclusion - The dollar amount reported is based on the overpayment determined by an investigation, review, or audit of a provider (as opposed to total provider billings) and the number of months in the resulting exclusion period. The provider's overpayment amount is divided by the number of months in which the overpayment occurred to render a monthly average. This figure is then multiplied by the number of months the provider is excluded to yield a dollar value for the given exclusion. All such products are then summed to valuate all exclusions ordered during the reporting period.

During SFY 2008, Sanctions changed its methodology for calculating cost avoidance arising out of permanent exclusions. A maximum of 36 months is used for all permanent exclusion cost avoidance calculations (the prior practice was to multiply the monthly average by 240 months). This 36-month duration is both appropriate and conservative because it is the same as the mandatory re-enrollment period for Medicaid providers, sets a uniform exclusion period for both indefinite and permanent exclusions, and is 15 months less than the fifty-one-month average found in a census of indefinite exclusions recently conducted by OIG Sanctions staff.

The full amount of the dollar valuation of the given exclusion is reported as cost avoidance during the month in which the exclusion order is issued. Thus, the cost avoidance associated with a given provider's particular exclusion is taken only once. This approach both eliminates double counting and avoids the highly cumbersome process of tracking and valuating individual exclusions on a month-by-month basis. The methodology governing definite temporary exclusions remains unchanged.

Third Party Resources

Medicaid provider claims denied by the Claims Administrator claims processing system when there is other insurance identified – These are actual denied claims in which the recipient was identified as having other insurance. The claims payment system denies the claim when other insurance must be billed prior to billing Medicaid.

General Investigations

Disqualifications Cost Avoidance – Disqualification cost avoidance dollars are calculated by multiplying the number of months each recipient is disqualified times the program-specific monthly allotment (presently $122.00 for Food Stamps and $126.00 for TANF) and then summing these individual products. The length of disqualification periods are based on federal regulations and state legislation and may be found in Section B-932 of the *Texas Works Handbook*. Disqualification periods for TANF intentional program violations occurring after September 1, 2003 are 12 months for the first offense and permanent for the second offense. TANF recipients convicted of a state or federal offense for conduct that constitutes an Intentional Program Violation (IPV) or granted deferred adjudication or placed on community supervision for such conduct

are permanently disqualified. Food stamp recipients are disqualified for one year for the first offense, two years for the second offense, and permanently for the third offense. Recipients found guilty of an IPV in federal or state court or an administrative disqualification hearing for making fraudulent statements or representations about residence or identity to receive multiple benefits simultaneously are barred for 10 years. When a recipient is found guilty of food stamp trafficking for $500 or more the disqualification is permanent.

Income Eligibility Verification System (IEVS) Data Match Cost Avoidance – In the process of investigating IEVS data matches, action notices are generated. These action notices alert HHSC Office of Eligibility Services (OES) staff to reduce or deny benefits based on income or resource information that may affect ongoing benefits. A sample of 141 cases with action notices was researched to validate the benefit and eligibility determinations and establish an average cost avoidance per action notice of $111.18. The total cost avoidance is the number of action notices generated multiplied by $111.18.

Recipient Data Match Cost Avoidance – Recipient data matches include Social Security Administration (SSA) Deceased Individual, Bureau of Vital Statistics (BVS) Deceased Individual, Prisoner Verification System, Texas Department of Criminal Justice (TDCJ), and Border State matches (Louisiana, Oklahoma, and New Mexico). In the process of investigating these data matches, action alert notices are sent to HHSC-OES staff to reduce or deny benefits based on household composition, residence, income, and resource information that may affect ongoing benefits.

A sample of 351 matches was researched to validate the benefit and eligibility determinations, and establish an average cost savings of $36.95 per match completed. The total cost avoidance is the number of recipient data matches completed multiplied by $36.95.

Technology Analysis, Development, and Support

Dollars that are not paid based on the provider being placed on prepayment review – Providers on prepayment review must submit paper claims with supporting documentation. The information is then reviewed to determine if the service is payable.

Women, Infants, and Children

Cost avoidance for Women, Infants, and Children (WIC) investigations is found by using the following methodology:

- Identify cases where fraud was identified and the recipient stopped redeeming vouchers as a result of being notified of the investigation;
- Calculate an average amount of redeemed vouchers per month from the most recent three months available for that WIC participant; and
- Apply that average to the remaining months of the active certification period of that recipient.

Example: Recipient A stops redeeming vouchers after being notified that an

investigation has identified fraud. Recipient A has two months of vouchers that are still active and does not spend them. The average amount of vouchers for the previous three months is $250. The cost avoided for this case would be $500 (2 months active vouchers x $250 average monthly-redeemed vouchers).

Audit

Cost avoidance results from four types of audit activities:

- *Cost Report Review (Desk Reviews/Performance Audits)* – Cost Avoidance from cost report work represents the net of disallowed costs and added costs identified in desk reviews and field audits of long-term care provider Cost Reports, 24-Hour Residential Child Care Cost Reports, and Attendant Compensation Reports for Community Care and Nursing Facility providers.

  The dollars removed from cost reports reduces the amount that flows into the rate-setting database maintained by HHSC's Rate Analysis Department (RAD). These dollars do not represent recouped amounts, because providers are paid a contract specified rate. The cost avoidance arises when this contractual rate is altered to account for audited disallowances.

  As of the Third Quarter of SFY 2007, OIG no longer includes these net disallowed costs in its reported cost avoidance because these cost savings are highly indirect vis-à-vis OIG, arise over indeterminate and provider-specific time periods, and extremely difficult, if not impossible, to track.

- *Contract Audit* – Represents unallowable costs and incorrect charges identified during an audit of unpaid contract claims and billings;

- *Medicaid/CHIP Audit (Oversight/Consulting)* – Cost avoidance is achieved by providing consultation to program management, overseeing outside audit contracts to ensure all appropriate questioned costs are considered, and identifying wasteful practices that can be eliminated in future contracts and expenditures; and

- *Outpatient Hospital/MCO Audit (Desk Reviews/Performance Audits)* – The dollars removed from Medicaid Outpatient Hospital cost reports reduces the amount that flows into the rate-setting database maintained by TMHP. These dollars do not represent recouped amounts, because providers are paid based upon a cost-to-charge ratio of Medicaid costs to all costs. The impact of these cost avoidance numbers are reductions reflected in the unit rate calculations used for interim payments to the hospitals and a savings through the time value of money.

End of Report